REPORT - HIPAA 837I to MMIS

| Loop | SegID | HIPAA Name | DT | Req | File | Field | DT | Comment | CommentType |
|--------|-------|---|------|-----|-------------------------|------------------------|-------|---|-------------|
| | | Health Care Claim: Institutional | | | | | | | |
| 1000A | NM1 | Submitter Name | | R | | | | | |
| 1000B | NM1 | Receiver Name | | R | | | | | |
| 2000A | HL | Billing/Pay-To Provider Hierarchical Level | | R | | | | For translator, we should estim. the max # providers per tx | Translation |
| 2010AA | NM1 | Billing Provider Name | | R | | | | Use 2010AB-Pay-to-Prov, unless only 2010AA-Billing-Prov is sent | Translation |
| 2010AB | NM1 | Pay-To Provider Name | | S | | | | | |
| 2000B | HL | Subscriber Hierarchical Level | | R | | | | For translator, we should approximate what is the max # subscribers per provider: rec. max. 5000? | Translation |
| 2000B | SBR09 | Claim Filing Indicator Code | ID2 | S | Institutional- Claim | CLM-INPUT-FORM-IND | X(1) | Store in MMIS for use in 835-CLP06; in this field? | Match Back |
| 2010BA | NM1 | Subscriber Name | | R | | | | | |
| 2010BA | NM109 | Subscriber Primary Identifier | AN80 | S | Institutional- Claim | RECIP-IDENT- NUMBER | X(14) | Match back required | Match Back |
| 2010BB | NM1 | Credit/Debit Card Account Holder Name | | S | | | | | |
| 2010BC | NM1 | Payer Name | | R | | | | | |
| 2010BD | NM1 | Responsible Party Name | | S | | | | | |
| 2000C | HL | Patient Hierarchical Level | | S | | | | | |
| 2010CA | NM1 | Patient Name | | R | | | | | |

| Loop | SegID | HIPAA Name | DT | Req | File | Field | DT | Comment | CommentType |
|-------|-------|--------------------------------------|-----------|-----|-------------------------|-------------------------|-------|--|----------------|
| 2300 | CLM | Claim information | | R | | | | | |
| 2300 | CLM05 | Facility Type Code | AN2 | R | Institutional- Claim | PLACE-OF-SERVICE | X(1) | Expand to 2 digits and convert to standard values | Match Back |
| 2300 | REF02 | Claim Original Reference Number | AN30 | R | Institutional- Claim | TCN-TO-CREDIT | 9(17) | store & return in 835 | Match Back |
| 2300 | REF02 | Medical Record Number | AN30 | R | Institutional- Claim | PATIENT-ACCT- NUMBER | X(20) | need longer field; store & return in 835 loop 2100 040 REF01=EA | Match Back |
| 2305 | CR7 | Home Health Care Plan Information | | S | | | | | |
| 2310A | NM1 | Attending Physician Name | | S | | | | | |
| 2310B | NM1 | Operating Physician Name | | S | | | | | |
| 2310C | NM1 | Other Provider Name | | S | | | | | |
| 2310D | NM1 | Referring Provider Name | | S | | | | | |
| 2310E | NM1 | Service Facility Name | | S | | | | | |
| 2320 | SBR | Other Subscriber Information | | S | | | | Not more than 2 other payers | Electronic COB |
| 2330A | NM1 | Other Subscriber Name | | R | | | | | |
| 2330B | NM1 | Other Payer Name | | R | | | | | |
| 2330C | NM1 | Other Payer Patient Information | | S | | | | | |
| 2330D | NM1 | Other Payer Attending Provider | | S | | | | | |
| 2330E | NM1 | Other Payer Operating Provider | | S | | | | | |
| 2330F | NM1 | Other Payer Other Provider | | S | | | | | |

| Loop | SegID | HIPAA Name | DT | Req | File | Field | DT | Comment | CommentType |
|-------|-------|---|-----|-----|------|-------|----|---|---------------|
| 2330G | NM1 | Other Payer Referring Provider | | S | | | | | |
| 2330H | NM1 | Other Payer Service Facility Provider | | S | | | | | |
| 2400 | LX | Service Line Number | | R | | | | | |
| 2400 | SV202 | Product or Service ID Qualifier | ID2 | R | | | | Store & send back in 835 SVC01-1 | Match Back |
| 2420A | NM1 | Attending Physician Name | | S | | | | add all available providers to claim at service line level also | Policy Issues |
| 2420B | NM1 | Operating Physician Name | | S | | | | | |
| 2420C | NM1 | Other Provider Name | | S | | | | | |
| 2420D | NM1 | Referring Provider Name | | S | | | | | |
| 2430 | SVD | Service Line Adjudication Information | | S | | | | | |

Comment Type Legend:

Column Heading Legend: "DT" = Data Type

Case Management = "Nice to Have" fields for case reviewers.

Electronic COB = If we do electronic COB, these fields will be needed.

HIPAA Questions = Questions about interpreting the HIPAA Implementation Guides.

HIPAA Required = Required fields in HIPAA that don't seem to be in the legacy system.

Map Codes = Need to crosswalk local codes to standard codes.

Match Back = Fields received on an incoming transaction that must be returned in the response.

Nice to Have = Optional fields that are useful for other reasons.

Policy Issues = Decisions to be made by system experts.

Processing Logic = Logic that needs to be built into either the front end or MMIS.

System Questions = Questions about the legacy systems.

Translation = Only use to program translations.

COBOL Data Types Legend:

X(n) - Character data with length of n bytes

9(n) - Integer data with length of n bytes

S9(n) - Signed integer data with length of n bytes

9(n)V99 or 9(n)V9(2) - Numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

S9(n)V99 or S9(n)V9(2) - Signed numeric data with n decimal digits before the decimal point and 2 decimal digits after the decimal point

HIPAA Data Types Legend:

ANn - Free text with length of n bytes

IDn - Coded value with length of n bytes

Nn - Numeric data with length of n bytes

Rn - Real data with length of n bytes

DT8 - Date expressed as CCYYMMDD

TM8 - Time expressed as HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds ((00-99)